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KENSINGTON ALGONQUIN, LLC	ONE BALTIMORE STREET CUMBERLAND, MD 21502

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E 000	Initial Comments From December 4 through 6, 2013, a renewal survey was conducted at the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations. Survey activities included the review of: policy and procedures, six (6) resident records, seven (7) staff records, administrative records, interviews with the Assisted Living Manager (ALM), Delegating Nurse/Case Manager #1 (DN/CM) and other staff and residents. A tour of the facility was completed on December 4, 2013. At the start of the survey process on December 4, 2013, the facility's census was reportedly sixty four (64) residents'. Based on the renewal survey findings, the following deficiencies were identified;	E 000		
E2550	.19 B2 .19 Other Staff--Qualifications (2) As evidenced by a physician's statement be free from: (a) Tuberculosis, measles, mumps, rubella, and varicella through appropriate screening procedures such as tuberculosis skin tests, positive disease histories, or antibody serologies; and (b) Any impairment which would hinder the performance of assigned responsibilities; This REQUIREMENT is not met as evidenced by: Based on staff record reviews on 12/04/13 the facility failed to ensure that all staff records contained; a physician statement and documentation to support immunity to measles, mumps, rubella, and varicella as evidenced by history of disease or vaccination.	E2550		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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E2550	Continued From page 1 Findings included: 1. The AALM record failed to contain documentation to support immunity to varicella. 2. The part time DN/CM's record failed to contain a physician statement and documentation to support immunity rubella. 3. Staff #1's Employee Health Survey documented Staff #1 had not had mumps. Review failed to reveal documentation of immunization. Review revealed Staff #1 signed an attestation he was "free of all communicable disease" however further review failed to reveal documentation of a positive disease history or appropriate screening procedure for mumps. 4. Staff #2's Employee Health Survey was left blank for measles, mumps, and rubella.	E2550		
E2600	.19 B6,7 .19 Other Staff--Qualifications (6) Receive initial and annual training in: (a) Fire and life safety, including the use of fire extinguishers; (b) Infection control, including standard precautions, contact precautions, and hand hygiene; (c) Basic food safety; (d) Emergency disaster plans; and (e) Basic first aid by a certified first aid instructor; (7) Have training or experience in: (a) The health and psychosocial needs of the population being served as appropriate to their job responsibilities; (b) The resident assessment process; (c) The use of service plans; and	E2600		

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E2600	Continued From page 2 (d) Resident's rights; and This REQUIREMENT is not met as evidenced by: Based on staff record reviews and interview with the ALM, the facility failed to ensure documentation was available to support initial and on-going/annual training's were completed. Findings included: 1.) The part time DN/CM's training record failed to contain documentation to support initial training in basic first aid with certification of training. 2.) The AALM training record failed to contain documentation to support initial training in health and psychosocial process, resident assessment and the use of service plans.	E2600		
E2780	.20 C .20 Delegating Nurse C. Duties. The delegating nurse shall: (1) Be on-site to observe each resident at least every 45 days; (2) Be available on call as required under this chapter or have a qualified alternate delegating nurse available on call; and (3) Have the overall responsibility for: (a) Managing the clinical oversight of resident care in the assisted living program; (b) Issuing nursing or clinical orders, based upon the needs of residents; (c) Reviewing the assisted living manager's assessment of residents; (d) Appropriate delegation of nursing tasks; and (e) Notifying the OHCQ: (i) If the delegating nurse's contract or	E2780		

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E2780	Continued From page 3 employment with the assisted living program is terminated; and (ii) Of the reason why the contract or employment was terminated. This REQUIREMENT is not met as evidenced by: Based on resident record reviews and interview with the ALM, the DN/CM #2 failed to assume overall responsibility for: 1) Ensuring all treatments/medications are administered consistently with applicable requirements of COMAR 10.27.11 (Nurse Practice Act)-and Maryland Board of Nursing (MBON) Medication Technicians' (MT) Course; 2.) Ensuring adequate initial, 45-day reviews and 90 day reviews are completed as required, 3.) Ensuring service plans are completed and appropriate oversight of medical services 4.) Reviewing the assisted living manager's assessment of each resident. Findings include: Resident #5 1.) DN/CM #2 failed to ensure adequate self-medicating reviews were completed for the resident initially and every 90 days as required. (Refer to tag 3560) The previous DN/CM failed to ensure the resident's medication practice was assessed every 90 days as required. Three (3) assessments were found in the resident's record and were dated as 3-2-13, 9-20-13 and 11-4-13. More than 90 days had passed between 3-2-13 and 9-20-13 assessments. 2.) DN/CM #2 failed to ensure medical services were documented on the resident's service plan to ensure the facility's unlicensed MT received proper directions for the completion of medical services.	E2780		

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E2780	Continued From page 4 3.) The resident's full admission assessment was completed on 2/21/13. The DN/CM #2 documented the full assessment was reviewed on 9/2/12. However, DN/CM #2 failed to acknowledge that the resident's communicable disease portion of the assessment had not been completed as required. Resident #3 1.) Review of the resident's record revealed the resident was transferred to the local hospital twice in November 2013. The resident reportedly was transferred out on 11/1/13 with complaints of chest pain. The resident returned to the facility on 11/5/13 and DN/CM #2 completed the new resident assessment tool on 11/6/13 but failed to complete the new service plan as required when utilizing the new assessment form. 2.) The resident was transferred back out to the hospital on 11/12/13 for dehydration and returned to the facility on 11/16/13. The DN/CM #2 failed to complete a new resident assessment tool. The resident's service plan was last dated as being reviewed on 8/7/13; therefore the resident's service plan was not up-dated upon return to the facility on 11/16/13. 3.) Review of the resident's 45 day reviews/comprehensive assessments revealed the forms were completed by DN/CM #2 on 3/25/13 and 9/25/13. More than 45 days had occurred between 3/25/13 and 9/25/13. Resident #1 1.) The resident was admitted to the facility on 10/25/13 and review of the resident's record revealed two resident assessment tools were completed. The transferring facility completed a resident assessment tool (utilizing old forms) dated 10/17/13 by a Registered Nurse (RN). DN/CM #2 completed a new resident assessment	E2780		

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E2780	Continued From page 5 tool (utilizing the Departments new assessment tool) on admission. The resident's record failed to contain a functional assessment and scoring tool for the 10/17/13 assessment tool. In addition, the resident's record failed to contain the new service plan that is required when utilizing the new resident assessment tool on admission. 2.) The resident was transferred to the local emergency room (ER) on 12/2/13 after drinking two and a half bottles of whiskey and falling on the facility's front door steps and lacerating his head and requiring six (6) staples for closure. The resident's record failed to contain a resident assessment tool (old or new) for the significant change that occurred on 12/2/13. In addition, a service plan had not been initiated as required on admission and therefore was not up-dated with services related to drinking and head trauma. The facility's DN/CMs' are required to ensure all medical services are documented onto the resident's service plan. 3.) The resident's record failed to have a comprehensive assessment to support the DN/CM assessed the resident's medical condition upon return from the ER on 12/2/13. Resident #2 1.) Review of the resident's record on 12/05/13 failed to reveal a service plan. The surveyor requested Service Plans on the dates of the survey; none were provided. Resident #2 was admitted to the facility on 10/31/13. 2.) Review of the resident's record revealed the resident was on Coumadin, a high risk medication which requires monitoring, was assessed as at risk for falls, and had diagnoses that included epilepsy, gait ataxia, and high blood pressure.	E2780		

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E2780	Continued From page 6 Resident #6 Review of Resident #6's record revealed numerous diagnoses including polysubstance abuse, alcohol abuse, hepatic encephalopathy, and cirrhosis. Further record review revealed the resident continued to engage in behaviors that are self-injurious. The 10/08/13 Resident Assessment Tool by DN/CM #2 noted the resident continues to consume alcohol and after consuming alcohol has become agitated and verbally aggressive with staff. The 11/18/13 Comprehensive Nursing Assessment by DN/CM #1 documented the resident was diagnosed with alcohol dementia with short term memory loss and impaired decision making. DN/CM#1 did not note any self injurious behaviors/aggressive behaviors that were documented in the progress/weekly care notes by staff. (Refer to Tag E3960). Nursing overview by the DN/CM includes the development and evaluation of resident Service Plans.	E2780		
E3370	.26 C2 .26 Service Plan (2) The service plan is developed within 30 days of admission to the assisted living program; and This REQUIREMENT is not met as evidenced by: Based on resident record reviews and interview with the ALM the facility failed to ensure service plans were completed within 30 days of the resident's admission when utilizing the old resident assessment tool and on admission when utilizing the new resident assessment tool. Findings include:	E3370		

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E3370	Continued From page 7 Resident #5 The resident was admitted to the facility on 3/2/13. Review of the resident's record on 12/5/13 revealed that the resident's service plan was not completed or initially signed and dated by the individual that initiated the start of the resident's service plan. However, an attachment to the service plan documented that the resident's service plan was reviewed by four (4) staff on 9/26/13. Resident #1 The resident was admitted to the facility on 10/25/13. Review of the resident's record on 12/5/13 revealed that the resident's service plan had not been initiated as required on admission. Resident #2 Review of the resident's record on 12/05/13 revealed the resident was admitted to the facility on 10/31/13. Further review failed to reveal a Service Plan.	E3370		
E3420	.27 D .27 Resident Record or Log D. Resident Care Notes. (1) Appropriate staff shall write care notes for each resident: (a) On admission and at least weekly; (b) With any significant changes in the resident's condition, including when incidents occur and any follow-up action is taken; (c) When the resident is transferred from the facility to another skilled facility; (d) On return from medical appointments and when seen in home by any health care provider; (e) On return from nonroutine leaves of absence; and (f) When the resident is discharged permanently	E3420		

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E3420	Continued From page 8 from the facility, including the location and manner of discharge. (2) Staff shall write care notes that are individualized, legible, chronological, and signed by the writer. This REQUIREMENT is not met as evidenced by: Based on resident record review the facility failed to ensure resident care notes documented an initial admission note and then weekly notes as required. Findings include: 1. Resident #5's record failed to contain an initial admission note for 3/2/13. 2. Review Resident #1, #3 and #5's care notes revealed weekly care notes were not being completed as required. Weekly care notes stopped the week of 11/18/13 for the three residents'.	E3420		
E3560	.29 E .29 Medication Management and Administration E. For a resident who is capable of self-administration or, although capable, requires a reminder or physical assistance, as stated in §D(2) of this regulation, the assisted living manager shall ensure that the resident is reassessed by the delegating nurse quarterly for the ability to safely self-administer medications with or without assistance. This REQUIREMENT is not met as evidenced by: Based on Resident #5's record review,	E3560		

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E3560	Continued From page 9 observation of the resident's self-medication abilities, and resident interview on 12/6/13, the DN/CM failed to complete an adequate assessment of the resident's self-medication administration skills and review of medications being administered by the resident. Findings include: Interview with Resident #5 with review of medications and administration practices revealed the following deficient practices: 1.) Resident #5's bedroom was not locked upon entering his bedroom. Medications were observed unsecured on top of the small kitchen counter. Two weekly pill containers were observed with medications contained within and a few bottles of medications were sitting out on the counter. A bigger container of pill bottles was removed from the kitchen cabinet. COMAR 10.07.14.L.(1) & (2) 2.) The medications were not maintained within their original container as required and the resident was not able to identify the pills within the pill containers. COMAR 10.07.14.L.(1) & (2) 3.) Interview with the resident revealed the resident did not know the names of the medications or the reason for each medication ordered. The resident said that he can read and was able to put the pills into the containers. 4.) The facility's list of medications that the resident reportedly was taking did not compare with the medication found in the resident's room. The resident stated that no one has come into his room to review his medications with him. Eight (8) medications found in the resident's room were not on the facility' list of medications. The dose of Synthroid (for hypothyroidism) had changed twice from the dose that was originally written on the facility medication list. The resident stated that he	E3560		

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E3560	Continued From page 10 stopped taking his Lasix (fluid pill). The resident's Nitrostat (emergency heart medication) ordered for chest pain had expired on 3/27/12. A clear plastic bottle contained several pills and the bottle was labeled "Ex-lax" with a permanent black pen. No direction for use, strength of pills or expiration date was documented. 5.) The resident's record revealed a self-medication review was completed by the DN/CM #2 on admission on 3/2/13; however the resident's Nitrostat had expired prior to admission. The next two (2) resident assessments were dated 9-20-13 and 11-4-13, however neither documented the above errors observed on 12/6/13.	E3560		
E3680	.29 M .29 Medication Management and Administration M. Medications and treatments shall be administered consistent with current signed medical orders and using professional standards of practice. This REQUIREMENT is not met as evidenced by: Based on resident record review, observation, and interview of DN/CM#1 and staff, medications transcribed onto Medication Administration Records (MAR) were not consistent with current signed orders and staff failed to follow standard medication administration procedure. Findings included: RESIDENT #2 1.) Observation of a 12/04/13 medication pass by Staff #3, a MT, revealed staff was preparing to	E3680		

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E3680	Continued From page 11 administer Coumadin 2mg. (milligrams) to the resident. Review of the MAR revealed "HOLD" was written in the 12/02/13-12/04/13 medication boxes indicating the medication was not to be administered. The surveyor asked the MT why the dose was being administered and the MT stated that LPN #1 told the MT not to hold the medication. Review of the medication orders in the MAR book failed to have any documentation regarding holding/administering Coumadin on those dates. Staff had initialed over the hold on 12/02/13 and 12/03/13 that doses were administered. The surveyor contacted DN/CM#1 and the 12/04/13 dose was held until the DN/CM could clarify. Interviews with DN/CM#1 and LPN #2 revealed the LPN stated the resident was scheduled for a dental procedure and she had contacted the dentist who told her it was not necessary to hold the Coumadin. The LPN had not documented this information. The LPN was not sure who wrote HOLD on the MAR but she noted "error" above instead of re-writing the medication on the MAR. The DN/CM followed up with the healthcare provider on 12/04/13 and the provider ordered the 12/04/13 Coumadin held. 2.) Review of the November and December, 2013 MAR's revealed Cyclobenzaprine 10 mg. at bedtime as needed transcribed onto the MAR. Review of the signed admission physician order list revealed Cyclobenzaprine 5 mg at bedtime as needed. The current pharmacy medication order form noted Cyclobenzaprine 10 mg at bedtime as needed. Further review failed to reveal a physician order changing the dosage. Interview with DN/CM#1 on 12/05/13 revealed the DN/CM investigated the discrepancy during the survey and stated the pharmacy had changed the dosage in error.	E3680		

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E3680	Continued From page 12 RESIDENT #6 Review of the December, 2013 MAR revealed staff was to apply Ketoconazole shampoo topically three times weekly. Further review revealed staff initialed the MAR 12/1/13- 12/04/13 indicating daily application.	E3680		
E3790	.31 C .31 Incident Reports C. All incident reports shall include: (1) Time, date, place, and individuals present; (2) Complete description of the incident; (3) Response of the staff at the time; and (4) Notification, including notification to the: (a) Resident, or if appropriate the resident's representative; (b) Resident's physician, if appropriate; (c) Program's delegating nurse; (d) Licensing or law enforcement authorities, when appropriate; and (e) Follow-up activities, including investigation of the occurrence and steps to prevent its reoccurrence. This REQUIREMENT is not met as evidenced by: Based on review of residents incident reports the facility failed to ensure all required documentation was recorded on each incident report as required. Findings include: 1.) Review of Resident #1's record revealed the resident had drank two and a half bottles of whiskey on 12/2/13 and fell outside on the front door steps of the assisted living facility at 1:30 am. The resident lacerated his head during the fall that requires six (6) staples at the local emergency room. The incident report	E3790		

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E3790	Continued From page 13 documented the resident was in and out of consciousness. The incident report failed to document preventative measure for the resident's inappropriate and dangerous behavior. Review of the resident's service plan revealed no documentation or interventions to support oversight of behavior by the assisted living facility. 2.) Review of the facility's incident reports for the last two weeks of October 2013 revealed several incident reports failed to document; clear description of events, preventative measure taken by staff and notification of DN/CM: a.) Incident report for bedroom 609 on 10/13/13 at 10:00 am documented a check mark to indicate the resident fell. Staff documented that the resident was found in a "Sitting position up against door". Reportedly the resident's phone rang and the resident lost their footing while trying to get the phone. The DN/CM signed the incident report on 10/17/13, four days after the incident occurred and no documentation was found to support the DN/CM was called at the time of incident. The incident report failed to document any preventive measures. b.) Incident report for bedroom 420 on 10/13/13 at 7:15 am indicated the type of incident as "other" and documented that the resident "Slide off the couch while sleeping". Continued review of the incident report revealed that staff documented the resident was "Unable to tell me (staff member) what happened". Staff failed to document a clear description of events based on conflicting documentation. The DN/CM signed the incident report on 10/17/13, four days after the incident occurred. The incident report failed to document a preventive measure. c.) Incident report for bedroom 510 on 10/27/13 at 8:30 am indicated the type of incident as "other" and documented that the resident "Slide	E3790		

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E3790	Continued From page 14 from bed." No injuries were documented. Staff documented that the resident's "bed is too high" for the resident and the resident "has a hard time getting in and out of bed". The DN/CM signed the incident report the next day; however the area for preventative measures was left blank. d.) Incident report for bedroom 420 on 10/29/13 at 5:00 am indicated the type of incident as "fall" and documented that the resident "Rolled off of couch". The preventive measure was documented as "What could be done is put bed rails on bed and put resident to bed at night". The DN/CM failed to sign this incident report as reviewed. Bed rails are not appropriate as a restrictive devise that may cause injury instead of preventing it.	E3790		
E3860	.33 D .33 Relocation and Discharge D. In the event of a health emergency requiring the transfer to an acute care facility, a copy of an emergency data sheet shall accompany the resident to an acute care facility. This data sheet shall include at least: (1) The resident's full name, date of birth, Social Security number, if known, and insurance information; (2) The name, telephone number, and address of the resident's representative; (3) The resident's current documented diagnoses; (4) Current medications taken by the resident; (5) The resident's known allergies, if any; (6) The name and telephone number of the resident's physician; (7) Any relevant information concerning the event that precipitated the emergency; and (8) Appended copies of: (a) Advanced directives;	E3860		

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E3860	Continued From page 15 (b) Emergency Medical Services (EMS/DNR) Form; and (c) Guardianship orders or powers of attorney, if any. This REQUIREMENT is not met as evidenced by: Based on resident record review and interview of the ALM, the facility failed to ensure the Emergency Data sheet contained all required information. Findings included: Review of Resident #2's Emergency Data Sheet on 12/05/13 failed to reveal documentation of all diagnosis relevant to the resident. Additionally, the sheet notes the resident is "CPR-Option A2" but further record review failed to reveal a copy of the MOLST (Medical orders for life sustaining treatment). The ALM stated the MOLST form was at the physician's office awaiting a signature.	E3860		
E3960	.35 A1,2 .35 Resident's Rights .35 Resident's Rights. A. A resident of an assisted living program has the right to: (1) Be treated with consideration, respect, and full recognition of the resident's human dignity and individuality; (2) Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations; This REQUIREMENT is not met as evidenced by: Based on resident record reviews and interviews	E3960		

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E3960	Continued From page 16 of DN/CM#1 and ALM, the facility failed to have documentation that the residents' service plan were reviewed and revised when interventions for behaviors with the potential to be harmful to self and/or others were ineffective. Findings included: Resident #5 The resident was admitted to the facility on 3/2/13 and failed to have a service plan that was completed and addressed his unsafe use of alcohol consumption. The resident fell on 12/2/13 at 1:30 am in the morning on the facility's outside front steps after consuming "two and one half bottles of whiskey". The incident report failed to document a preventive measure and the service plan was not up-dated to address significant change after the resident's ER visit, where six (6) staples were required to close the laceration to the resident's head. (Refer to Tag #3370 and #3790 findings #1) Resident #6 Review of Resident #6's record on 12/05/13 revealed the resident was admitted on 08/27/13 with extensive diagnoses including hepatic encephalopathy, cirrhosis, bipolar disorder, mood disorder, post traumatic stress disorder, alcohol induced dementia, and had a history of homicidal ideation, polysubstance abuse, and alcohol dependence. Admission paperwork provided by the Veteran's Administration (VA) revealed on 07/08/13 the VA plan included not using alcohol for the next six (6) months and not exhibiting behaviors that have the potential to be self-injurious and/or to upset others. Further review of the resident record revealed: a.) Progress notes documented on 09/03/13 the resident left the facility during the evening and	E3960		

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E3960	Continued From page 17	E3960		

remained out of the facility until 12:00 AM and returned smelling of alcohol. The resident also refused to smoke "in appropriate areas." On 09/10/13 staff documented the resident was observed utilizing stairs rather than the elevator and safety issues were discussed however resident continued to utilize stairs. On 09/23/13, the AALM met with Resident #6 regarding use of alcohol and continued use of stairs and safety issues. On 10/02/13 staff documented resident left facility on 10/01/13 and returned after consuming alcohol. The resident became verbally abusive toward staff and called then called 911. Resident was admitted to the hospital and was "physically and verbally violent" while in the emergency room. On 10/14/13 the resident was verbally abusive toward staff. On 12/04/13 staff documented resident has medications in his room that he stated were barbiturates. Notes documented the resident's medical provider had not prescribed any such medications. DN/CM#1 stated, during interview, the resident was not allowing staff into his room to see the medication and is threatening toward staff.

b.) Weekly care notes by staff documented on 10/28/13- "When drinking acts up and yells at people". On 11/04/13 staff documented- "Goes out in evening and misses meds." On 10/14/13- "Resident leaves facility at times to consume alcohol. Has been reported he is very angry/verbally abusive toward staff."

c.) Caregiver documentation noted on 09/20/13 "very aggressive tonight. Cursing at staff and he would be screaming & cursing at us in hallways of all floors and slamming things." On 10/01/13 staff documented "very loud & angry & rude."

d.) The 10/08/13 Resident Assessment Tool by DN/CM#2 noted disruptive behavior "also has hx (history) of alcoholism and continues to consume alcohol on regular basis. After consuming alcohol,

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E3960	Continued From page 18 resident has become agitated and verbally aggressive with staff." Unsafe behaviors included the continued use of alcohol. e.) DN/CM#1's 11/18/13 Comprehensive Nursing Assessment documented the resident was diagnosed with alcohol dementia with short term memory loss and impaired decision making. DN/CM#1 did not note she was aware of the self injurious behaviors/aggressive behaviors that were documented in the progress/weekly care notes by staff. Review of Resident #6's record on 12/05/13 revealed a blank "Interim Service Plan". During interviews with DN/CM#1 and ALM the surveyor requested the Service Plan for the resident. None was provided during the dates of the survey. Review of Resident #6's record revealed the resident was admitted to the facility on 08/27/13. The ALM faxed a service plan to the surveyor on 12/09/13 with notes stating DN/CM#2 had completed the plan. The typewritten plan was dated 09/27/13; the signature areas and corresponding date completed areas on page eleven were blank. The plan stated the resident "regularly consumes alcohol" (which is not provided by the facility and is obtained when the resident leaves the facility) and states "staff is to encourage resident to refrain from alcohol consumption" yet the plan further notes the resident goes on walks and "usually walks to town for the evening. Resident frequently returns to facility after 10pm" and care notes prior to 09/27/13 document the resident leaves the facility and consumes alcohol. The plan fails to develop interventions to address this behavior. Review of the resident record and interviews of DN/CM#1 and the ALM failed to reveal the facility had implemented effective interventions for	E3960		

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E3960	Continued From page 19 Resident #6, who exhibited behaviors that were self injurious and behaviors that were aggressive toward others. Interview with the ALM and DN/CM#1 revealed the resident's whereabouts are unknown during his absences' and staff does not know when he will return. Staff encouragement to refrain from alcohol consumption is not effective and the resident is consuming alcohol while away from the facility. Record review revealed the behaviors continued after 09/27/13. Review failed to reveal the facility reviewed and revised the resident service plan following continued self injurious behaviors/aggressive behaviors documented in the record that may place resident at risk of harm.	E3960		
E4630	.41 A .41 General Physical Plant Requirements .41 General Physical Plant Requirements. A. The facility, which includes buildings, common areas, and exterior grounds, shall be kept: (1) In good repair; (2) Clean; (3) Free of any object, material, or condition that may create a health hazard, accident, or fire; (4) Free of any object, material, or condition that may create a public nuisance; and (5) Free of insects and rodents. This REQUIREMENT is not met as evidenced by: Based on resident record review, interview of the AALM, and observation, the facility failed to ensure the environment was free from conditions that may create a health hazard. Findings included:	E4630		

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E4630	Continued From page 20 During a tour of the facility on 12/04/13 the surveyor observed a can of beer in 5th floor refrigerator and a bottle of beer in the 4th floor refrigerator. The refrigerators are located in front of the laundry rooms and accessible to all residents and staff. Resident record reviews on 12/05/13 revealed two residents had a history of alcohol dependence and documentation revealed both residents continued to drink alcohol against medical advice. The storage of alcoholic beverages in community refrigerators accessible to all residents creates a health risk.	E4630		
E4910	.46 E3 .46 Emergency Preparedness (3) Semiannual Disaster Drill. (a) The assisted living program shall conduct a semiannual emergency and disaster drill on all shifts during which it practices evacuating residents or sheltering in-place so that each is practiced at least one time a year. (b) The drills may be conducted via a table-top exercise if the program can demonstrate that moving residents will be harmful to the residents. (c) Documentation. The assisted living program shall: (i) Document completion of each disaster drill or training session; (ii) Have all staff who participated in the drill or training sign the document; (iii) Document any opportunities for improvement as identified as a result of the drill; and (iv) Keep the documentation on file for a minimum of 2 years. This REQUIREMENT is not met as evidenced by:	E4910		

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E4910	Continued From page 21 Based on review of the facility's disaster drills for 2012 and 2013, the facility failed to provide evacuation drills for all three (3) shifts for the first half of 2013. Findings include: The facility failed to have documentation to support evacuation drill was completed on evening shift for the first half of 2013.	E4910		